INFORMATION FOR COMPLETING THE X-RAY SUPERVISOR AND OPERATOR APPLICATION

1. **Delay in processing your application may be caused by failure to:**

   A. Complete the application.
   B Remit the application fee.
   C. Sign your application form.
   D. Submit all documents required for the certificate or permit requested.
   E. Enclose a copy of your California professional license.

2. **Requirements for Admission to Examination**:

   A. You must submit a copy of a wallet card or other document indicating that you hold a current California medical license or osteopathic, podiatric, or chiropractic medical license. In addition:

      For a **Radiology Supervisor and Operator Certificate:** submit a document attesting that you practice as a radiologist ***OR*** are in the examination process to become American Board of Radiology (ABR) or American Osteopathic Board of Radiology (AOBR) certified.

      For a **Radiography Supervisor and Operator Permit**: submit a signed statement that you have used X-rays in your practice or intend to use X-rays in the near future, ***OR*** that you have supervised X-ray personnel in the past or intend to supervise X-ray personnel in the near future.

      For a **Fluoroscopy Supervisor and Operator Permit applicant**: submit documentation attesting that you have used fluoroscopy equipment in a residency, fellowship, or formal postdoctoral clinical education program, or evidence that you are presently enrolled and will be required to use fluoroscopy equipment in a residency, fellowship, or formal postdoctoral clinical education program.

      For a **Dermatology Supervisor and Operator Permit**: submit a document attesting that you are certified by the American Board of Dermatology, ***OR*** that you are enrolled in a residency, fellowship, or formal postdoctoral education program in which you will be required to use dermatology X-ray equipment in the treatment of diseases of the skin.

   B. Please provide your name and address on the labels provided.

   C. If your application is approved, you will be scheduled for the appropriate examination(s). The Radiologic Health Branch (RHB) will send you study material(s) and an admission letter indicating the examination booklet(s) you will take and the date, time, and location of the examination(s).

   D. If your application is not approved, RHB will inform you of the reason(s) for which your application is not approved at this time.

3. **Examination Information**

   A. To obtain a **Radiology Supervisor and Operator Certificate**, you must pass both the Fluoroscopy and Radiography examinations (see B and C below).

      NOTE: If you are ABR or AOBR certified, you are exempt from taking the state radiation protection examination. However, you must submit: (1) a completed application, (2) a copy of your ABR or AOBR certificate, and (3) the proper application fee.

   B. To obtain a **Fluoroscopy Supervisor and Operator Permit**, you must pass the fluoroscopy radiation protection and safety examination. This permit is necessary if you use or supervise someone who uses fluoroscopy and ancillary equipment on human beings.

   C. To obtain a **Radiography Supervisor and Operator Permit**, you must pass the radiography radiation protection and safety examination. This permit is necessary if you use or supervise someone who uses radiography and ancillary equipment on human beings.

   D. To obtain a **Dermatology Supervisor and Operator Permit**, you must pass the dermatology radiation protection and safety examination. This permit is necessary if you use or supervise the use of X-ray therapy for the treatment of diseases and tumors of the skin.

3. **Examination Results**

   RHB will notify you of your examination results approximately 30 calendar days following the examination for which you were scheduled. Examination results will not be given over the telephone.

X-RAY SUPERVISOR AND OPERATOR APPLICATION

Please read information before completing application. **Print legibly. Complete all entries that apply to you.**

Last name	First name	Middle initial	Date of birth	Gender ☐ Male ☐ Female

Mailing address (number, street)	Apartment/suite number

City	State	ZIP code	Home telephone number
			( )

Social security number	E-mail address	Fax number	Work telephone number
		( )	( )

NOTE: "All information on this application is releasable to the public. You may submit a P.O. box number rather than a home address if no other business address is available." California Public Records Act (PRA), Government Code, Sections 6250, et seq.

Professional license number: _____

NOTE: ***Application will not be acceptable without a copy of your current professional license.***

Classification: ☐ M.D. ☐ D.P.M. ☐ D.C. ☐ D.O.

Medical specialty (check only one)

1. ☐ Cardiology
2. ☐ Dermatology
3. ☐ Diseases of the chest
4. ☐ Eyes, Ears, Nose and Throat
5. ☐ Gastroenterology
6. ☐ General Practice
7. ☐ General Surgery
8. ☐ Internal Medicine
9. ☐ Emergency Medicine
10. ☐ Obstetrics and Gynecology
11. ☐ Orthopedics
12. ☐ Family Practice
13. ☐ Pediatrics
14. ☐ Radiology
15. ☐ Urology
16. ☐ Podiatry
17. ☐ Chiropractic
18. ☐ Radiation Oncology
19. ☐ Other: _____

Request for Certificate or Permit

☐ Radiology Supervisor and Operator certificate
☐ Fluoroscopy Supervisor and Operator permit
☐ Radiography Supervisor and Operator permit
☐ Dermatology Supervisor and Operator permit

I prefer to take the California certification examination in:

☐ Northern California ☐ Southern California In the month of _____

Prior Certification

☐ American Board of Radiology ☐ American Osteopathic Board of Radiology Date certified _____

X-Ray Equipment

Do you ☐ Own ☐ Possess (rent or lease) X-ray equipment? ☐ Yes ☐ No

If answer is yes, please indicate type of equipment you own or possess

☐ Radiographic ☐ Fluoroscopic ☐ Other _____

Declaration: ***I certify that the foregoing is true and accurate.***

Signature of applicant	Date

DEPARTMENT OF HEALTH SERVICES' USE ONLY

Certificate number: _____

Classification code: _____

Date coded: _____

Coded by: _____

Mail application, supporting documents, and fee (see applicable fee schedule) **to:**

Mailing address:

Department of Health Services
Radiologic Health Branch—Certification
P.O. Box 942833, MS 178
Sacramento, CA 94234-2833

FOR EXPRESS DELIVERY ONLY:

Department of Health Services
Radiologic Health Branch—Certification
601 North Seventh Street, MS 178
Sacramento, CA 95814